RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

CERTIFICATE OF NEED FOR HEARING AID

_____
Name of Patient

_____
Address

This is to certify that an otological examination of the above-named patient demonstrates a hearing impairment of such a nature as to indicate the need for a hearing aid instrument or hearing prosthetic device. (chap. 177 Public Laws of 1978)

Signed:_____ MD/DO

Name: _____
Please print or type

Date:_____

Address:_____

_____

Physician's Copy (Pink)

CERTIFICATE OF NEED FOR HEARING AID

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Name of Patient

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Signed: _____ MD/DO

Name: _____
Please print or type

Date:_____

Address:_____

_____

Dealer's Copy (White)